January 1–December 31, 2023

2023
Summary of Benefits

Kaiser Permanente Senior Advantage Care Plus (HMO-POS)

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KAISER PERMANENTE®

About this Summary of Benefits

Thank you for considering Kaiser Permanente Senior Advantage Care Plus. You can use this **Summary of Benefits** to learn more about our plan. It includes information about:

- Premiums
- Benefits and costs
- Part D prescription drugs
- Optional supplemental benefits (Advantage Plus)
- Additional benefits, including Point-of-Service (POS) benefits
- Who can enroll
- Coverage rules
- Getting care

For definitions of some of the terms used in this booklet, see the glossary at the end.

For more details

This document is a summary of 1 Kaiser Permanente Senior Advantage Care Plus plan that includes Medicare Part D prescription drug coverage. It doesn't include everything about what's covered and not covered or all the plan rules. For details, see the **Evidence of Coverage (EOC)**, which is located on our website at **kp.org/eocga** or ask for a copy from Member Services by calling **1-800-232-4404** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

We also offer a plan without Part D drug coverage. If you'd like information about our other plan, call **1-877-408-3493** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week or go to **kp.org/medicare**.

Kaiser Permanente Senior Advantage Care Plus plan has a Point-of-Service (POS) benefit. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. Not all services are covered under POS. Covered services under POS are noted in the "Additional benefits" section and also in your **EOC**.

Have questions?

- If you're not a member, please call **1-877-408-3493** (TTY **711**).
- If you're a member, please call Member Services at **1-800-232-4404** (TTY **711**).
- 7 days a week, 8 a.m. to 8 p.m.

What's covered and what it costs

*Your plan provider may need to provide a referral.
†Prior authorization may be required.

Benefits and premiums	You pay
Monthly plan premium	**$0**
Deductible	**None**
Your maximum out-of-pocket responsibility Includes copays and other costs for medical services for the year. Doesn't include Medicare Part D drugs.	**$6,500**
Inpatient hospital coverage*† There's no limit to the number of medically necessary inpatient hospital days.	**$295** per day for days 1 through 6 of your stay and **$0** for the rest of your stay
Outpatient hospital coverage†	**$0–$275** per visit
Ambulatory Surgery Center†	**$275** per visit
Doctor's visits • Primary care providers	**$10**
• Specialists*	**$35** per visit
Preventive care See the **EOC** for details.	**$0**
Emergency care We cover emergency care anywhere in the world.	**$95** per Emergency Department visit
Urgently needed services We cover urgent care anywhere in the world.	**$35** per visit
Diagnostic services, lab, and imaging*† • Lab tests • Diagnostic tests and procedures (like EKG)	• **$0** per encounter in a medical office • **$35** per encounter in an outpatient hospital department
• X-rays	• **$10** per encounter in a medical office • **$50** per encounter in an outpatient hospital department
• MRI, CT, and PET	• **$210** per encounter in a medical office • **$290** per encounter in an outpatient hospital department
Hearing services • Evaluations to diagnose medical conditions	**$35**
• 1 routine hearing exam per calendar year Hearing aids and related exams aren't covered unless you sign up for optional benefits (see Advantage Plus for details).	**$0**

Benefits and premiums	You pay
Dental services • Preventive – Two oral exams, two teeth cleanings, and two X-rays per calendar year.	**$0**
• Comprehensive*† – refer to the **Evidence of Coverage** for the list of covered services. Note: You receive additional comprehensive dental when you sign up for optional benefits (see Advantage Plus for details).	**$0-$580**, depending on the service
Vision services • Visits to diagnose and treat eye diseases and conditions	**$35** per visit
• 1 routine eye exam per calendar year • Preventive glaucoma screening and diabetic retinopathy services	**$0**
• Eyeglasses or contact lenses after cataract surgery	**20%** coinsurance up to Medicare's limit and you pay any amounts beyond that limit.
• Other eyewear ($500 allowance to purchase eyewear every 2 years)	If your eyewear costs more than $500, **you pay the difference**.
Mental health services • Outpatient group therapy	**$17** per visit
• Outpatient individual therapy	**$35** per visit
Skilled nursing facility*† We cover up to 100 days per benefit period.	Per benefit period: • **$0** per day for days 1 through 20 • **$196** per day for days 21 through 100
Physical therapy*	**$35** per visit
Ambulance	**$225** per one-way trip
Transportation To get you to and from plan providers.	**$0** for 18 one-way trips per calendar year.
Medicare Part B drugs† A limited number of Medicare Part B drugs are covered when you get them from a plan provider. See the **EOC** for details. • Drugs that must be administered by a health care professional	**0%-20%** coinsurance depending on the drug
• Up to a 30-day supply from a plan pharmacy	• **$0** for generic drugs • **$47** for brand-name drugs

Medicare Part D prescription drug coverage†

The amount you pay for drugs will be different depending on:

- The tier your drug is in. There are 6 drug tiers. To find out which of the 6 tiers your drug is in, see our Part D formulary at **kp.org/seniorrx** or call Member Services to ask for a copy at **1-800-232-4404** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.
- The day supply quantity you get (like a 30-day or 90-day supply). Note: A supply greater than a 30-day supply isn't available for all drugs.
- For drugs in Tiers 3–4, when you get a 31- to 90-day supply, whether you get your prescription filled by one of our retail plan pharmacies or our mail-order pharmacy. Note: Not all drugs can be mailed.
- The coverage stage you're in (deductible, initial coverage, coverage gap, or catastrophic coverage stages).
- **Important Message About What You Pay for Insulin** – You won't pay more than **$35** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.
- **Important Message About What You Pay for Vaccines** – Our plan covers most Part D vaccines at no cost to you.

Note: Medicare provides Extra Help to pay prescription drug costs for people who have limited income and resources. If you are entitled to Extra Help, the cost-sharing below may not apply to you; instead please refer to the **Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs**.

Deductible stage

Because we have no deductible, this payment stage does not apply to you and you start the year in the initial coverage stage.

Initial coverage stage

You pay the copays and coinsurance shown in the chart below until your total yearly drug costs reach **$4,660**. (Total yearly drug costs are the amounts paid by both you and any Part D plan during a calendar year.) If you reach the $4,660 limit in 2023, you move on to the coverage gap stage and your coverage changes.

Drug tier	You pay
Tier 1 (Preferred generic)	**$0** (up to a 90-day supply)
Tier 2 (Generic)	**$0** (up to a 90-day supply)
Tier 3 (Preferred brand-name)	**$47** (up to a 30-day supply)
Tier 4 (Nonpreferred brand-name)	**$95** (up to a 30-day supply)
Tier 5 (Specialty)	**33%** coinsurance
Tier 6 (Vaccines)	**$0**

When you get a 31- to 90-day supply of drugs in Tiers 3-4 from one of our **retail plan pharmacies**, the copays listed above in the chart will be multiplied as follows:

- If you get a 31- to 60-day supply from one of our retail plan pharmacies, you pay 2 copays.
- If you get a 61- to 90-day supply from one of our retail pharmacies, you pay 3 copays.

When you get a 31- to 90-day supply of drugs in Tiers 1-4 from our **mail-order pharmacy**, the copays are as follows:

- You pay **$0** for drugs in Tiers 1 and 2.
- You pay 2 copays for drugs in Tiers 3 and 4.

Note: For a 31- to 90-day supply of drugs in Tier 5, you pay the coinsurance listed above in the chart.

Coverage gap stage

The coverage gap stage begins if you or a Part D plan spends **$4,660** on your drugs during 2023. You pay the following copays and coinsurance during the coverage gap stage:

Drug tier	You pay
Tiers 1, 2, and 6	The same copays listed above that you pay during the initial coverage stage
Tiers 3, 4, and 5	**25%** coinsurance

Catastrophic coverage stage

If you or others on your behalf spend **$7,400** on your Part D prescription drugs in 2023, you'll enter the catastrophic coverage stage. Most people never reach this stage, but if you do, your copays and coinsurance will change for the rest of 2023. You pay the following copays per prescription during the catastrophic coverage stage:

Drug	You pay
Generic drugs	**$5**
Brand-name drugs	**$15**
Part D vaccines	**$0**

Long-term care, plan home-infusion, and non-plan pharmacies

- If you live in a **long-term care facility** and get your drugs from their pharmacy, you pay the same as at a retail plan pharmacy and you can get up to a 31-day supply.
- Covered Part D **home infusion** drugs from a plan home-infusion pharmacy are provided at no charge.
- If you get covered Part D drugs from a **non-plan pharmacy**, you pay the same as at a retail plan pharmacy and you can get up to a 30-day supply. Generally, we cover drugs filled at a non-plan pharmacy only when you can't use a network pharmacy, like during a disaster. See the **Evidence of Coverage** for details.

Advantage Plus (optional benefits)

In addition to the benefits that come with your plan, you can choose to buy a supplemental benefit package called Advantage Plus. Advantage Plus gives you extra coverage for an additional monthly cost that's added to your monthly plan premium. See the **Evidence of Coverage** for details.

Advantage Plus benefits and premiums	**You pay**
Additional monthly premium	**$9**
Hearing aids† $500 allowance to buy 1 aid, per ear every 3 years	If your hearing aid costs more than $500 per ear, **you pay the difference**.
Dental care - comprehensive*† DeltaCare® USA Dental HMO Program	Varies depending on the comprehensive dental service. See the **Evidence of Coverage** for details.

Additional benefits

These benefits are available to you as a plan member:	**You pay**
Point-of-Service (POS) Care Plus out-of-network benefit When you are anywhere in the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits, outpatient tests and services, and Part B drugs obtained from out-of-network Medicare providers not to exceed a benefit maximum of **$1,500** in covered plan charges per calendar year. Covered services, include, but are not limited to: • Primary care and specialty care visits. • Mental health care outpatient visits. • Outpatient tests and services, such as lab tests, X-rays, and ultrasounds. • Medicare Part B drugs. For coverage details, including a full list of covered services, how to locate an eligible provider, how to schedule an appointment, and claims, please see the Medical Benefits Chart, Chapter 4, in the **Evidence of Coverage**.	You pay the following up to the **$1,500** annual benefit limit: • **$50** per specialty care visit. • **$50** per mental health care individual therapy visit or **$25** per mental health care group therapy visit. • **$50** per lab test or X-ray. • **$50** per ultrasound. • **$50** for blood, including storage and administration. • **$25** per primary care visit. • **$0** for preventive care visits. • You pay **20% of the provider's fee schedule** for Medicare Part B drugs administered in an office or clinic. Once you reach the maximum plan benefit coverage amount of **$1,500** per calendar year, you pay any amounts that exceed the benefit maximum.
Home medical care not covered by Medicare (acute medical care at home)** We cover medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status, to provide you with an alternative to receiving or	**$0** when prescribed as part of your home treatment plan, otherwise you pay the applicable cost share

These benefits are available to you as a plan member:	You pay
continuing to receive acute care in a hospital. Referral and prior authorization are required. See the **EOC** for details.	
Over-the-Counter (OTC) items We cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items each quarter of the year (January, April, July, October). The catalog lists the price of each item. Each order must be at least **$20**. Any unused portion of the quarterly benefit limit doesn't carry forward to the next quarter. To view our catalog and place an order online, please visit **kp.org/otc/ga**. You may place an order over the phone or request a printed catalog be mailed to you by calling **1-844-232-6906** (TTY **711**), 8 a.m. to 8 p.m., Monday through Friday.	**$0** up to the **$115** quarterly benefit limit.
Special Supplemental Benefits for the Chronically Ill (Healthy Food Card)** Eligible members with certain chronic conditions receive a quarterly allowance to purchase approved foods, such as produce. This benefit will be available only to plan-identified members who have been diagnosed with: • Chronic alcohol and other drug dependence. • Autoimmune disorders. • Cancer. • Cardiovascular disorders. • Chronic heart failure. • Dementia. • Diabetes. • End-stage liver disease. • End-stage renal disease (ESRD). • Severe hematologic disorders. • HIV/AIDS. • Chronic lung disorders. • Chronic and disabling mental health conditions. • Neurologic disorders. • Stroke. Any unused allowance does not carry over to the next quarter. See the **EOC** for details.	Members that meet the criteria for this benefit will receive a pre-loaded debit card with a quarterly allowance of **$150** to purchase approved healthy foods.

**The benefit mentioned are part of a special supplemental program for the chronically ill. Not all members qualify.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your **Evidence of Coverage** for more information, including the cost-sharing that applies to out-of-network services.

Who can enroll

You can sign up for this plan if:

- You have both Medicare Part A and Part B. (To get and keep Medicare, most people must pay Medicare premiums directly to Medicare. These are separate from the premiums you pay our plan.)
- You're a citizen or lawfully present in the United States.
- You live in our plan's service area, which includes:
  - Barrow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, Newton, Rockdale, Spalding, and Walton
  - These ZIP codes in Paulding County: 30127, 30134, and 30141

Coverage rules

We cover the services and items listed in this document and the **Evidence of Coverage**, if:

- The services or items are medically necessary.
- The services and items are considered reasonable and necessary according to Original Medicare's standards.
- You get all covered services and items from plan providers listed in our **Provider Directory** and **Pharmacy Directory**. But there are exceptions to this rule. We also cover:
  - Care from plan providers in another Kaiser Permanente Region
  - Care covered under the Care Plus point-of-service benefit. See the **Evidence of Coverage** for details.
  - Emergency care
  - Out-of-area dialysis care
  - Out-of-area urgent care (covered inside the service area from plan providers and in rare situations from non-plan providers)
  - Referrals to non-plan providers if you got approval in advance (prior authorization) from our plan in writing

    Note: You pay the same plan copays and coinsurance when you get covered care listed above from non-plan providers. If you receive non-covered care or services, you must pay the full cost.

For details about coverage rules, including non-covered services (exclusions), see the **Evidence of Coverage**.

Getting care

At most of our plan facilities, you can usually get all the covered services you need, including specialty care, pharmacy, and lab work. To find our provider locations, see our **Provider Directory** or **Pharmacy Directory** at **kp.org/directory** or ask us to mail you a copy by calling Member Services at **1-800-232-4404** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Your personal doctor

Your personal doctor (also called a primary care physician) will give you primary care and will help coordinate your care, including hospital stays, referrals to specialists, and prior authorizations. Most personal doctors are in internal medicine or family practice. You must choose one of our available plan providers to be your personal doctor. You can change your doctor at any time and for any reason. You can choose or change your doctor by calling Member Services or at **kp.org**.

Help managing conditions

If you have more than one ongoing health condition and need help managing your care, we can help. Our case management programs bring together nurses, social workers, and your personal doctor to help you manage your conditions. The program provides education and teaches self-care skills. If you're interested, please ask your personal doctor for more information.

Notices

Appeals and grievances

You can ask us to provide or pay for an item or service you think should be covered. If we say no, you can ask us to reconsider our decision. This is called an appeal. You can ask for a fast decision if you think waiting could put your health at risk. If your doctor agrees, we'll speed up our decision.

If you have a complaint that's not about coverage, you can file a grievance with us. See the **Evidence of Coverage** for details about the processes for making complaints and making coverage decisions and appeals, including fast or urgent decisions for drugs, services, or hospital care.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-232-4404 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-232-4404 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-232-4404 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-232-4404 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-232-

4404 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-232-4404 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-232-4404 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-232-4404 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-232-4404 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-232-4404 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-232-4404 (TTY 711) سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-232-4404 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-232-4404 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-232-4404 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-

800-232-4404 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-232-4404 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、
1-800-232-4404 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, sexual orientation, gender identity. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-232-4404** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to Attention: Member Services, Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Privacy

We protect your privacy. See the **Evidence of Coverage** or view our **Notice of Privacy Practices** on **kp.org/privacy** to learn more.

Helpful definitions (glossary)

Allowance

A dollar amount you can use toward the purchase of an item. If the price of the item is more than the allowance, you pay the difference.

Benefit period

The way our plan measures your use of skilled nursing facility services. A benefit period starts the day you go into a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't gotten any inpatient hospital care or skilled care in an SNF for 60 days in a row. The benefit period isn't tied to a calendar year. There's no limit to how many benefit periods you can have or how long a benefit period can be.

Calendar year

The year that starts on January 1 and ends on December 31.

Coinsurance

A percentage you pay of our plan's total charges for certain services or prescription drugs. For example, a 20% coinsurance for a $200 item means you pay $40.

Copay

The set amount you pay for covered services — for example, a $20 copay for an office visit.

Deductible

It's the amount you must pay for Medicare Part D drugs before you will enter the initial coverage stage.

Evidence of Coverage

A document that explains in detail your plan benefits and how your plan works.

HMO-POS

An HMO-POS plan is an HMO plan with a Point-of-Service (POS) benefit. "Point-of-Service" means you can use providers outside the plan's network for certain services for an additional cost

Maximum out-of-pocket responsibility

The most you'll pay in copays or coinsurance each calendar year for services that are subject to the maximum. If you reach the maximum, you won't have to pay any more copays or coinsurance for services subject to the maximum for the rest of the year.

Medically necessary

Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Non-plan provider

A provider or facility that doesn't have an agreement with Kaiser Permanente to deliver care to our members.

Plan

Kaiser Permanente Senior Advantage.

Plan premium

The amount you pay for your Senior Advantage health care and prescription drug coverage.

Plan provider

A plan or network provider can be a facility, like a hospital or pharmacy, or a health care professional, like a doctor or nurse.

Prior authorization

Some services or items are covered only if your plan provider gets approval in advance from our plan (sometimes called prior authorization). Services or items subject to prior authorization are flagged with a † symbol in this document.

Region

A Kaiser Foundation Health Plan organization. We have Kaiser Permanente Regions located in Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

Retail plan pharmacy

A plan pharmacy where you can get prescriptions. These pharmacies are usually located at plan medical offices.

Kaiser Permanente is an HMO-POS plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal. This contract is renewed annually by the Centers for Medicare & Medicaid Services (CMS). By law, our plan or CMS can choose not to renew our Medicare contract.

For information about Original Medicare, refer to your **"Medicare & You"** handbook. You can view it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

kp.org/medicare

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